

involving rare cancers. The increased life expectancy of HAART treated patients, a direct involvement of HIV itself, or abnormalities driven by oncogenic viruses, including EBV, HSV-8, and papillomavirus,^{1,2} might explain the tendency to develop a broader spectrum of long term neoplastic complications. In our experience, a persistent HIV associated immunodeficiency and an incomplete virological response to HAART, possibly had a pathogenetic role. Clinicians should maintain an elevated clinical suspicion for a broad spectrum of HIV associated cancer, even after a first diagnosis of AIDS related neoplasm. Epidemiological studies should give a reliable estimate of the frequency of all HIV associated tumours, and recognise eventual dual AIDS associated cancers. The pathogenesis underlying AIDS related malignancies (especially neoplasm immunity and viral oncogenesis) deserve careful insight.

Contributors

RM collected and interpreted data and literature evidences, and drafted the entire work; LC collected clinical and laboratory data and literature evidences, and revised both data evaluation and discussion; FC proposed and supervised the report, read and corrected the draft, and participated in the discussion of both data and literature references

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Impact of the Sexually Transmitted Infections Foundation course on the knowledge of family planning nurses and doctors

There has been convergence of genitourinary medicine and reproductive healthcare services in the United Kingdom to produce "one stop sexual health clinics" such as the Sandyford Initiative in Glasgow.¹⁻³ As part of service

Table 1 The mean (SD), median precourse and post-course scores, and mean difference in scores

	Precourse score	Post-course score	Mean difference (95% CI)
All participants (n=18)			
Mean (SD)	8.2 (2.3)	10.7 (1.8)	+2.5 (1.1 to 3.9)
Median	9.0	12.0	
Doctors (n=15)			
Mean (SD)	8.6 (1.9)	10.6 (1.8)	+2.0 (0.7 to 3.3)
Median	9.0	12.0	
Nurses (n=3)			
Mean (SD)	6.0 (3.0)	11.0 (1.7)	+5.0 (-3.6 to 13.6)
Median	6.0	12.0	

development a number of educational initiatives such as the Sexually Transmitted Infection Foundation (STIF) course have been initiated to ensure that minimum skills and competencies are obtained. Training programmes such as the STIF course coordinated by the Medical Society for the Study of Venereal Diseases (MSSVD) play a vital part in providing staff with the education required to competently extend their roles. The first Scottish STIF course was run in Glasgow in March 2002. The course was developed as a UK-wide initiative to support the implementation of the English national strategy for sexual health and HIV.⁴

In order to evaluate the impact attendance at the STIF course had on the knowledge of family planning staff, a prospective study was performed in Glasgow. Eighteen members of family planning staff (15 doctors and three nurses) were assessed on their knowledge of vaginal and cervical infections before and after attendance at the course, using four clinical case scenarios with accompanying clinical pictures. A maximum score of 12 was awarded for each assessment. The cases comprised candida, trichomonas, bacterial vaginosis, and chlamydia. The participants were asked to provide a provisional diagnosis based on the history and a clinical picture. The vaginal pH was then provided and each participant was given the opportunity to alter their diagnosis in the light of this additional information. They were then asked about the management of each condition. Within 3 months of the STIF course, each doctor and nurse were retested with the initial scenarios. Answers and feedback were provided on completion.

Two sample *t* tests and confidence intervals for the difference of two means were employed to compare all participants and the doctors and nurses scores before and after attendance at the STIF course. One sample *t* tests and confidence intervals for the difference of two means were employed to compare the doctors and nurses scores. As the numbers in the study were small a subanalysis of the results for different grades of doctors was not performed. Table 1 shows the mean (SD), median precourse and post-course scores, and mean difference in scores. The mean increases in all participants' and the doctors' scores were statistically significant ($p = 0.001$, and $p = 0.006$, respectively). The mean increase in the nurses' score was 5.0 (95% CI -3.6 to 13.6), however the number of nurse participants was small ($n=3$).

This study suggests that knowledge increased following attendance at the STIF course. Educational initiatives such as the STIF course are important tools for development of staff working in the field of sexual

and reproductive health care. A larger study of this type assessing a wider range of subject matter with longer follow up would enable further evaluation of the STIF courses' impact on knowledge.

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Improving response rates for self collected urine samples

Chlamydia trachomatis is the commonest bacterial sexually transmitted infection (STI) in Victoria, Australia, with the number of notifications increasing threefold in the past 8 years from 1287 in 1994 to 3977 in 2001.¹ As infection with chlamydia is frequently asymptomatic, notification data underestimate population prevalence. Innovative study designs are necessary to investigate chlamydia prevalence and risk factors. We conducted a pilot study among women aged 18-32, to estimate the rate of response to a request to provide a mailed self collected urine specimen for chlamydia testing. Recruitment via mail was compared with recruitment via mail and follow up telephone contact.

Between March and May 2002, the names and addresses of 150 Victorian women aged 18-32 were randomly selected from the electoral roll. These were linked with the Electronic White Pages and telephone numbers obtained where possible, producing two groups: (1) women with telephone numbers identified, and (2) women without telephone numbers identified. All women were mailed a letter of invitation and an information leaflet. Women in group 2 were also mailed a reply paid participation form asking them to indicate whether they wished to participate.

Women in group 1 were telephoned after 1 week and consent sought to mail them a urine kit. Two reminder letters were sent to non-responders in group 2. Women testing positive